10313 Aboite Center Road
Fort Wayne, IN 46804
Phone: (260) 459-6040
Fax: (260) 459-6010

10820 Coldwater Road
Fort Wayne, IN 46845
Phone: (260) 755-1438
Fax: (260) 755-1566

Assignment of Benefits and Release of Information

Client Name:	
Client Date of Birth:	
Insurance Company:	
Policy Number:	Group Number:
Insurance Company Address:	
Insurance Company Phone:	
Insured's/Guarantor Name:	
Insured's Date of Birth:	
Insured's Employer:	

I authorize the release of any medical or other information necessary to process my medical claim. I authorize payment of medical benefits to **Children's Autism Center, Inc.,** for services which facility and /or employees provide. **I understand I am financially obligated to pay for all services provided by Children's Autism Center, Inc. and/or its employees.**

Authorized Signature:_____

Printed Name:_____

Date:_____